Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
518-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

BRINKER, MARK R
7401 S. MAIN STREET
HOUSTON TX 77030-4509

DWC Claim #:
Injured Employee:
Date of Injury:
Employer Name:
Insurance Carrier #:

Respondent Name

TRAVELERS INDEMNITY CO

Carrier's Austin Representative Box

Box Number 05

MFDR Tracking Number

M4-10-4130-01

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary as taken from the Request for Reconsideration letter: "We are disagreeing with your decision for the fact that it was not based on the **new fee schedule thru work comp as of 3/1/08 the fees were updated and therefore this claim should be reprocessing and issue the provider the additional amount we are due**."

Amount in Dispute: $35.44

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider performed and billed a high level office visit (CPT code 99214) for $155.00, with CPT code 73060 at $75.00. The Carrier reviewed the billing and reimbursed the Provider $146.89 based on the negotiated contract between the Provider and the Carrier's medical contract vendor…This Provider is contracted under the Beech Street PPO MAX contract. This contract was effective 02-01-2006 and has not been renegotiated since that time. The Carrier has reviewed the reimbursement calculations, and confirmed the Provider was properly reimbursed under the terms of the contract."

Response Submitted by: Travelers; 1501 South Mopac Expwy. Ste A 320; Austin TX 78746

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
August 28, 2009	CPT Code 99214 CPT code 73060	$33.30 $ 2.14	$35.44

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.4 sets out the provisions for written notification to health care providers of contractual agreements for informal and voluntary networks.
2. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
3. 28 Texas Administrative Code §134.203 sets forth the medical fee guideline for professional services.
4. The services in dispute were reduced/denied by the respondent with the following reason codes:

   Explanation of benefits dated June 24, 2009 and July 20, 2009
   - AFFL 45 – charges exceed your contracted/legislated fee arrangement. This bill has been reviewed/repriced in accordance with your fee for service contract with First Health
   - Z024 45 - charges exceeds fee schedule/mixable allowable or contracted/legislated fee arrangement. The difference between the fee schedule amount and the amount paid is your PPO discount

Issues

1. Did the carrier respond to a request for additional information?
2. Did the insurance carrier meet the requirements of §133.4?
3. Is the insurance carrier entitled to pay the health care provider at a contracted rate?
4. Is the requestor entitled to additional reimbursement?

Findings

1. According to the explanation of benefits, the respondent denied reimbursement based upon "AFFL 45 – charges exceed your contracted/legislated fee arrangement. This bill has been reviewed/repriced in accordance with your fee for service contract with First Health" and "Z024 45 - charges exceeds fee schedule/mixable allowable or contracted/legislated fee arrangement. The difference between the fee schedule amount and the amount paid is your PPO discount". Former Texas Labor Code §413.011(d-1) states in pertinent part, "…an insurance carrier may pay fees to a health care provider that are inconsistent with the fee guidelines adopted by the Division if the insurance carrier…has a contract with the health care provider and that contract includes a specific fee schedule…" On September 22, 2010 the Division requested additional information. Specifically, medical fee dispute resolution requested a copy of the contract between the informal/voluntary network and Fondren Orthopedic Group, LLP and documentation to support that the requestor was notified in accordance with commissioner rule 28 Texas Administrative Code §133.4 titled *Written Notification to Health Care Providers of Contractual Agreements for Informal and Voluntary Networks.* The respondent provided a copy of the requested documentation.

2. 28 Texas Administrative Code §133.4(d) sets out that the notice must include the elements stated in (d)(1) and (d)(2), and may be provided through a website link only if the website satisfies the requirements of (d)(4)(A) and (B). Furthermore, §133.4 (e) titled *Documentation* requires that ...The informal or voluntary network, insurance carrier, or the insurance carrier's authorized agent, as appropriate, shall document the information provided in the notice as required by subsection (d) of this section, the method of delivery, to whom the notice was delivered, and the date of delivery. The written notification submitted for review was addressed to Covenant Medical Center, Lakeside; 3615 19th Street; Lubbock, Texas. The requestor in this dispute is Fondren Orthopedic Group, LLP; 7401 South Main Street; Houston, Texas. Therefore, "failure to provide notice that complies with the requirements of Labor Code §413.011 and this section creates a rebuttable presumption in a Division enforcement action and in a medical fee dispute that the health care provider did not receive the notification."

3. 28 Texas Administrative Code §133.4(g) states, in pertinent part, that "...The insurance carrier is not entitled to pay a health care provider at a contracted rate negotiated by an informal or voluntary network if: (1) the notice to the health care provider does not meet the requirements of Labor Code §413.011 and this section..." Because the respondent failed to notify the requestor to this dispute, the respondent is not entitled to pay at the First Health contracted rate. For this reason, the Division finds that reason codes "AFFL 45" and "Z024 45" are not supported. Accordingly, the additional reimbursement for the disputed services shall be calculated pursuant to the applicable division fee guideline.

4. The maximum allowable reimbursement (MAR) is calculated according to per 28 Texas Administrative Code §134.203(c) (1):
   - CPT 99214: 53.68 ÷ 36.0666 x $93.22 = $138.75 minus carrier's previous payment of $105.45 = $33.30
   - CPT 73060: 53.68 ÷ 36.0666 x $29.28 = $43.58 minus carrier's previous payment of $41.44 = $2.14

Conclusion

For the reasons stated above, the Division finds that the requestor has established that additional reimbursement is due. As a result, the amount ordered is $35.44.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to additional reimbursement for the services involved in this dispute. The Division hereby ORDERS the respondent to remit to the requestor the amount of $35.44 plus applicable accrued interest per 28 Texas Administrative Code §134.130 due within 30 days of receipt of this Order.

Authorized Signature

		MAY 31, 2012
Signature	Medical Fee Dispute Resolution Officer	Date

YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **twenty** days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. The party seeking review of the MDR decision shall deliver a copy of the request for a hearing to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §148.3(c), including a **certificate of service demonstrating that the request has been sent to the other party**.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.